# Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

## What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

The Department's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary; and
- Safe and effective.

## Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP.

## Who is eligible for EPSDT screenings?

The Department covers EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- Are covered by a Benefit Service Package (BSP) that covers EPSDT.

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

**Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and they are not eligible for services. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

## Are clients enrolled in one of the Department's Managed Care plans eligible for EPSDT?

**Yes!** EPSDT screenings are included in the scope of service provided by the Department's managed care plans. When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

**Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

**Do not bill the Department for EPSDT services. They are included in the managed care plan's reimbursement.**

## Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

**Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

## Billing for Infants Not Yet Assigned a ProviderOne Client ID

Use the ProviderOne Client ID of either parent for a newborn if the infant has not yet been issued a ProviderOne Client ID. Enter indicator **B** in the *Comments* section of the claim form to indicate that the parent's ProviderOne Client ID is being used for the infant. When using a parent's ProviderOne Client ID for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For parents enrolled in a Department managed care plan, the plan is responsible for providing medical coverage for the newborn(s).**

## What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

## What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:

    - ✓ How to clean teeth as they erupt;
    - ✓ How to prevent baby bottle tooth decay;
    - ✓ How to look for dental disease;
    - ✓ Information on how dental disease is contracted;
    - ✓ Preventive sealant; and
    - ✓ Application of fluoride varnish, when appropriate;

- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

Licensed providers may perform these components separately; however, the Department encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

## Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening components listed on the previous page:

- Appropriate audiometric tests (CPT codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high risk environments (CPT code 83655). Use ICD-9-CM diagnosis code V15.86 or V82.5 (Special screening for other conditions, chemical poisoning, and other contamination) when billing.

## How often should EPSDT screenings occur?

The following are Washington State's schedules for health screening visits. Payment is limited to the recommended schedules listed below:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.

  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old

- Three screening examinations are recommended between the ages of 1 and 2 years.

- One screening examination is recommended per 12-month period for children ages 2 through 6.

- One screening examination is recommended per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

## Foster Care Children

The Department pays providers an enhanced rate for EPSDT screening exams for foster care clients who receive their medical services through the Department's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

If ProviderOne indicates the child is in foster care, the provider must bill one of the following screening codes with modifier TJ to receive the enhanced rate:

- **D** (Division of Developmental Disabilities client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

The Department pays providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier TJ.

## Foster Children Initial Health Evaluation (IHE)

### What is the purpose of an IHE?

The purpose of this evaluation is to identify any:

- Immediate medical, urgent mental health, or dental needs the child may have; and
- Additional health conditions of which the foster parents and caseworker should be aware.

### Who is eligible?

Only clients 18 years of age and younger are eligible for an IHE.

### What is included in an IHE?

An IHE includes the following:

- **Careful measurement of height and weight for all children, and head circumference for children younger than 3** – This may reveal growth delays or reflect poor nutritional or general health status.

- **Careful examination of the entire body to include the unclothing of each body surface at some point during the examination -** Because some children entering foster care have been victims of physical or sexual abuse, note and document the following:

  - ✓ Any signs of recent or old trauma;
  - ✓ Bruises;
  - ✓ Scars;
  - ✓ Deformities; or
  - ✓ Limitations in the function of body parts or organ systems.

- **Appropriate imaging studies to screen for a recent or healing fracture -** Consider if there is a history of physical abuse before placement or if signs of recent physical trauma are present.

- **Genital and anal examination (male or female).**

- **Laboratory tests for HIV and other sexually transmitted diseases –** Perform when indicated clinically or by history.

- **Documentation and prompt treatment of other infections and communicable diseases.**

- **Evaluation of the status of any known chronic illness -** To ensure that appropriate medications and treatments are available.

> **Note:** Discuss specific care instructions directly with the foster parents and caseworker.

## What fee does the Department pay?

Payment is set at the maximum allowable fee for children's office calls.

To view the EPSDT fee schedule, go to www.hrsa.dshs.wa.gov/RBRVS/index.html.

> **Note:** The Department does not pay for an IHE on the same date of service as an EPSDT examination.

## How do I bill?

When you provide a foster child with the IHE within 72 hours of entering out-of-home placement, bill the Department using the following guidelines:

- Bill the appropriate evaluation and management (E&M) code (new patient codes 99201 – 99205 or established patient codes 99211 – 99215);

- Use ICD-9-CM diagnosis code V72.85 as the primary diagnosis; and

- Use modifier TJ.

If you bill an E&M code with the diagnosis code V72.85, but without modifier TJ, the Department will deny the claim.

> **Important Note:** The IHE is not an EPSDT examination because it is not as complex or thorough. If you feel an EPSDT examination is necessary, perform the EPSDT examination within 72 hours of out-of-home placement and bill the Department for the exam. The child will not require the IHE.

## What are the documentation requirements?

Providers must either:

- Document the IHE on the Foster Care Initial Health Evaluation form (DSHS 13-843); or
- Include documentation in the client's record that addresses all elements addressed in the "What is included in an IHE" section of this memorandum or on the Foster Care Initial Health Evaluation form.

To view and download the Foster Care Initial Health Evaluation form, go to http://www1.dshs.wa.gov/msa/forms/eforms.html and scroll down to the appropriate form number.

To receive the enhanced rate, providers are required to use either:

- The Department "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)] (see Important Contacts section for information on obtaining Department forms); **or**
- Another charting tool with equivalent information.

To download an electronic copy of the Well Child Examination form, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.

## What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

| If an EPSDT screening is requested through… | For clients who are… | Must be scheduled within… |
|---|---|---|
| The Department's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs) | Infants – within the first 2 years of life. | 21 days of request. |
| | Children – two years and older. | Six weeks of request. |
| | Receiving Foster Care – Upon placement | 30 days of request, or sooner for children younger than 2 years of age. |
| Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP) | Birth through 20 years of age | 14 days of the request. |
| **Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.** | | |

## What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate Department provider or the Department's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

**Note:** If the provider is using the parent's ProviderOne Client ID to bill Evaluation and Management (E&M) codes 99201-99215 for an infant who has not yet been assigned a ProviderOne Client ID, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

## Referrals

### Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

### Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

### Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. The Department reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions ***only***. The Department does not reimburse for orthodontic treatment for other conditions.

### Fetal Alcohol Syndrome (FAS) Screening

FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, and/or a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen, every child six months of age or older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or if there is suspicion of facial characteristics of FAS or microcephaly.

# Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

The Department pays for the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

| Procedure Code | Limitations |
|---|---|
| 97802 | 1 unit = 15 minutes; maximum of 2 hours (8 units) per year |
| 97803 | 1 unit = 15 minutes; maximum of 1 hour (4 units) per day |
| 97804 | 1 unit = 15 minutes; maximum of 1 hour (4 units) per day |

# Topical Fluoride **(HCPCS codes D1203 and D1204)**

The Department covers topical fluoride for eligible clients according to the Department's *Dental Program for Clients Through Age 20 Billing Instructions* and *Dental Program for Clients Age 21 and Older Billing Instructions*.

# Special Immunization Requirements for EPSDT Exams

The Department pays for the administration of GARDASIL® (Human Papillomavirus [Types 6,11,16,18] Recombinant Vaccine) when providers bill with CPT code 90649 (H papilloma vacc 3 dose im) in the following manner:

- **For clients age 9-18 years of age:**

  The Department pays for the administration of GARDASIL® only if it is obtained at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program. The Department pays for the administration of the vaccine only and not the vaccine itself. Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90649 SL). The Department reimburses for the administration for those vaccines that are free from DOH.

- **For clients age 19 and 20 years of age:**

  Bill the Department for the cost of the GARDASIL® vaccine itself by reporting procedure code 90649. DO NOT use modifier SL with any of the vaccines for clients 19 to 20 years of age. The Department reimburses for the vaccine using the Department's maximum allowable fee schedule. Bill the Department for the vaccine administration using either CPT codes 90471 or 90472.

  **Note:** The Department will not reimburse for GARDASIL® for any other age group. The Department limits payment for immunization administration to a maximum of two administration codes (e.g., one unit of 90471 and one unit of 90472).

GARDASIL® is administered in a series of three shots. To be paid by the Department, the physician must prescribe and administer the GARDASIL® series only:

- After the physician has performed an EPSDT exam; and
- To eligible clients on Medicaid programs.

The EPSDT exam is only required prior to the first shot in the series. Clients on TAKE CHARGE, Family Planning Only, and the Alien Emergency Only program are not eligible for this service.

# Immunizations - Children

**(This applies to clients age 20 years and younger. For clients age 21 years and older, refer to "Immunizations-Adults" on page C.11.)**

Immunizations covered under the EPSDT program are listed in the Fee Schedule. For those vaccines that are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under, the Department pays only for the administration of the vaccine and not the vaccines themselves. These vaccines are identified in the Comments column of the Fee Schedule as "free from DOH."

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained in this section.

## Clients 18 years of age and younger – "Free from DOH"

- These vaccines are available at no cost from DOH. Therefore, the Department pays only for administering the vaccine.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). The Department reimburses for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).

- DO NOT bill CPT codes 90471-90472 or 90465-90468 for the administration.

- If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you bill the E&M code without modifier 25 on the same date of service as a vaccine administration, the Department will deny the E&M code.

**Exception**: If an immunization is the only service provided (e.g., an immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25. The brief history must be documented in the client record.

**Note**: The above policy **does not** apply to E&M CPT codes 99381-99385, and 99391-99395 used for EPSDT screening visits. The Department will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M codes.

| No Cost Immunizations from Department of Health[1] | | |
|---|---|---|
| **Procedure Code** | **Description** | **Comments** |
| 90633 | Hep a vacc, ped/adol, 2 dose | Free from DOH for children |
| 90648 | Hib vaccine, prp-t, im | Free from DOH for children |
| 90649 | H papilloma vacc 3 dose im | Effective for dates of service on & after May 1, 2007: Free from DOH for 9- to 18-year-olds; allowed for 19-to 20-year-olds at fee; all others non-covered. |
| 90655 | Flu vaccine no preserv 6-35m, im | Free from DOH for children |
| 90656 | Flu vaccine no preserv 3 yo & >, im | Free from DOH for children |
| 90658 | Flu vaccine age 3 yo & over, im | Free from DOH for children |
| 90660 | Flu vaccine, nasal | Free from DOH for children ages 2 to 18 |
| 90669 | Pneumococcal vacc, ped <5, IM | Free from DOH for children |
| 90670 | Pneumococcal conjugate vaccine, 13 valent, for IM use | Free from DOH for ages 2 months to 71 months – routinely recommended; catch up for some high risk clients up to 18 years of age as a booster. |
| 90680 | Rotovirus vacc 3 dose, oral | Effective for dates of service on & after May 1, 2007: Covered only if free from DOH for children younger than age 1 (52 weeks). |
| 90698 | Dtap-hib-ip vaccine, im | Effective for dates of service on & after 7/15/08: Covered only if free from DOH for children 0-18 years of age. |
| 90700 | Dtap vaccine, < 7 yo, im | Free from DOH for children |
| 90702 | Dt vaccine < 7 yo, im | Free from DOH for children |
| 90707 | Mmr vaccine, sc | Free from DOH for children |
| 90710 | Mmrv vaccine, sc | Free from DOH **for children only**, Non-covered for Adults. |
| 90713 | Poliovirus, ipv, sc/im | Free from DOH for children |
| 90714 | Td vaccine no prsrv >/= 7 yo, im | Free from DOH for children |
| 90715 | Tdap => 7 yo, im | Free from DOH for children |
| 90716 | Chicken pox vaccine, sc | Free from DOH for children |
| 90723 | Dtap-hep bi-ipv vaccine, im | Free from DOH **for children only**, Non-covered for Adults. |
| 90732 | Pneumococcal vaccine | Free from DOH for children |
| 90734 | Meningococcal Vaccine, IM | Free from DOH for children 0-18. EPA required for 19 yrs and older |
| 90744 | Hepb vacc ped/adol 3 dose im | Free from DOH for children |
| 90747 | Hepb vacc, ill pat 4 dose im | Free from DOH for children |
| G9142 | Influenza A H1N1, vaccine | Free from DOH for children and adults |

[1] For additional information, please see full MMWR Please Reference: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a2.htm#tab2.

## Clients 18 years of age and younger – "Not free from DOH"

- Bill the Department for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with these vaccines. The Department reimburses for the vaccine using the Department's maximum allowable fee schedule.

> **Note:** Unless otherwise noted, billing should reflect the usual and customary fee and not the Department's maximum allowable fee. Reimbursement is either the usual and customary fee or the Department's maximum allowable fee, whichever is less.

- Bill the Department for the vaccine administration using either CPT codes 90465-90468 or 90471-90472. ***Do not*** bill CPT codes 90465-90468 in combination with CPT codes 90471-90472. The Department limits reimbursement for immunization administration to a maximum of two administration codes (e.g., one unit of 90465 and one unit of 90466, one unit of 90467 and one unit of 90468, or one unit of 90471 and one unit of 90472).
  **For example:**

  - ✓ One unit of 90465* and one unit of 90466*;
  - ✓ One unit of 90467* and one unit of 90468*; or
  - ✓ One unit of 90471 and one unit of 90472.

> **Note:** The Department pays for the above starred (*) administration codes ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill the above administration codes on the **same** claim as the procedure code for the vaccine.

## Clients age 19-20 years – All Vaccines

- Bill the Department for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is available free-of-charge from DOH or not. The Department pays for the vaccine using the Department's maximum allowable fee schedule.

> **Note:** Unless otherwise noted, billing should reflect the usual and customary fee and not the Department's maximum allowable fee. Reimbursement is either the usual and customary fee or the Department's maximum allowable fee, whichever is less.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

> **Note:** Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA, please see Section I. For clients 18 years of age and younger, the Department does not require authorization when the vaccine is free from DOH.

# Immunizations-Adults

**(DOH supplies free vaccines for children 0-18 years only)**
**(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children")**

- Bill HCPCS code G9142 for the administration of H1N1 (Swine Flu) vaccine.
- Bill the Department for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- The Department reimburses providers for the vaccine using the Department's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.
- If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you bill the E&M code without modifier 25 on the same date of service as a vaccine administration, the Department will deny the E&M code.

  **Exception**: If an immunization is the only service provided (e.g., an immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25. The brief history must be documented in the client record.

**Note**: The above policy **does not** apply to E&M CPT codes 99381-99385, and 99391-99395 used for EPSDT screening visits. The Department will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M codes.

**Note:** Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA, please see Section I.

# Synagis®

**Note:** The Department does not reimburse immune globulins that are obtained free of charge.

## Requirements for Administration and Authorization of Synagis® for 2009 - 2010 RSV Season

The Department requires providers to follow the 2009 updated guidelines established by the American Academy of Pediatrics (AAP) for the administration of Synagis®.

**Note:** *This information relates only to those clients NOT enrolled in a Department managed care organization (MCO). For clients enrolled in a Department MCO, please refer to the coverage guidelines in the enrollee's plan.*

## Respiratory Syncytial Virus (RSV)/Synagis® Season

The Department has established the RSV/ Synagis® season as December through April. The Department monitors RSV incidence as reported by laboratories throughout the state and may change the dates based on the data collected.

Unless otherwise notified by the Department, these dates are firm.

## Criteria for Administration of Synagis® to Department Clients

The Department requires that the following guidelines and standards of care be applied to clients considered for RSV/Synagis® prophylaxis during the RSV season. The Department established these guidelines and standards using the AAP guidelines revised and updated in 2009.

Children younger than 2 years of age at the beginning of the coverage season are covered for up to a maximum of five doses for the season, regardless of start of treatment in relation to season start and end dates, if they have one of the following conditions:

✓ **Children with Chronic Lung Disease (CLD):**

- *For their* first *RSV season with CLD, clients* who have required medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within 6 months prior to the anticipated start of the RSV/ Synagis® season;

- *For their* second *RSV season with CLD, clients* who continue to require medical therapy, ***or*** **if treatment with Synagis is ordered by a neonatologist, pediatric intensivist, pulmonologist, or infectious disease specialist.**

✓ **Asthma** - Children with asthma who are on daily inhaled steroid therapy, but have persistent symptoms require evaluation by an asthma specialist or pulmonologist prior to authorization for Synagis®;

✓ **Immunocompromised –** Children with, for example, severe combined immunodeficiency or advanced acquired immunodeficiency syndrome;

✓ **Hemodynamically significant cyanotic, or acyanotic congenital heart disease** and ONE of the following:

- Receiving medication to control congestive heart failure;
- Moderate to severe pulmonary hypertension;
- Undergoing surgical procedures that use cardiopulmonary bypass; or
- Infants with cyanotic heart disease.

**Note:** The Department does ***not*** authorize Synagis® for the following groups of infants and children with congenital heart disease:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus);
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure; and
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

✓ **Children younger than 12 months of age at the beginning of the RSV/Synagis® season with significant congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory tract secretions -** These clients are covered for a maximum of five doses for the season during the first year of life only;

✓ **Children born at 28 weeks and 6 days gestation or earlier and younger than 12 months of age at the beginning of the RSV/Synagis® season** – These clients are covered for a maximum of five doses for the season, regardless of start of treatment in relation to RSV season start and end dates;

- ✓ **Children born at 29 weeks and 0 days through 31 weeks and 6 days gestation and younger than 6 months of age at the beginning of the RSV/Synagis® season** – These clients are covered for a maximum of five doses for the season, regardless of start of treatment in relation to RSV season start and end dates;

- ✓ **Children born at 32 weeks and 0 days through 34 weeks and 6 days gestation, younger than 3 months of age at the beginning of the RSV/Synagis® season**, and having one of the following risk factors:

  - ➢ Attending child care; or

  - ➢ Living with siblings younger than five years of age.

    Children who qualify under these criteria should receive Synagis® only until they reach 3 months of age and may receive a maximum of **three** doses of Synagis® during the season. This means that some children may only receive one or two doses, because of their age, during the RSV/Synagis® season. Payment for any doses beyond the three allowed or administered after 3 months of age will be considered an overpayment subject to recoupment.

## Other Considerations When Administering Synagis®

Administer the first dose of Synagis® 48 to 72 hours before discharge or promptly after discharge to infants who qualify for prophylaxis during the RSV/Synagis® season.

If an infant or child who is receiving Synagis® immunoprophylaxis experiences a breakthrough RSV infection, continue administering monthly prophylaxis for the maximum allowed doses as above.

> **Note:** The Department does not authorize Synagis® for children with cystic fibrosis.

## Authorization and Billing Procedures

**Please direct questions or concerns regarding billing and authorization of Synagis® to the Department's Pharmacy Authorization Unit at 1-800-848-2842. Fax prior authorization requests on completed Department prior authorization form(s) to 1-360-725-2122.**

**Bill the Department using the following guidelines:**

- ✓ Synagis® may be dispensed and billed by a retail pharmacy for administration by a physician, or may be billed by the physician's office;
- ✓ Pharmacies bill through standard pharmacy Point-of-Sale electronic claim submission using the appropriate National Drug Code for the product dispensed;
- ✓ Physician's offices billing directly for Synagis® must bill on a CMS-1500 or comparable electronic billing format using Current Procedural Terminology (CPT) code 90378;
- ✓ When requesting authorization for Synagis® use the "Request For Synagis (Not Managed Care/Healthy Options)" form, DSHS 13-771, and clearly indicate on page 2 whether a pharmacy or a physician's office is billing the Department.

## Criteria for Coverage or Authorization

Note: Criteria for coverage or authorization vary depending on the patient's age at the start of the RSV season.

**Clients Younger than One Year of Age for the Duration of RSV/Synagis® Season**

The Department requires providers to use and accurately apply the "Criteria for Administration of Synagis® to Department Clients." Billing for Synagis® outside of these guidelines will be considered an overpayment and will be subject to recoupment.

The Department will continue to cover Synagis® for clients younger than one year of age without authorization, as long as utilization is appropriate. In this case, physicians and pharmacies are not required to submit paperwork or obtain pre-approval for the administration of Synagis®.

**Clients Reaching One Year of Age During RSV/Synagis® Season**

The Department requires prior authorization to administer Synagis® to Department clients who are:

- ✓ Under one year of age at the start of RSV/Synagis® season; and
- ✓ Will reach their first birthday prior to the end of the season.

Prior authorization is required to administer Synagis® to children one year of age and older. Request authorization by faxing the "Request For Synagis (Not Managed Care/Healthy Options)" form, DSHS 13-771.

**Clients Between One and Two Years of Age at the Beginning of RSV/Synagis® Season**

Prior authorization is required to administer Synagis® to Department clients one year of age and older at the start of RSV/Synagis® season. Request authorization by faxing the "Request For Synagis (Not Managed Care/Healthy Options)" form, DSHS 13-771.

**Clients Older than Two Years of Age at the Beginning of RSV/Synagis® Season**

The Department does not pay for administering Synagis® to clients older than two years of age.

**Weight Changes for Clients One Year of Age and Older During RSV/Synagis® Season**

The quantity of Synagis® authorized for administration of Synagis® to clients one year of age and older is dependent upon their weight at the time of administration.

If you have obtained authorization for a quantity of Synagis® that no longer covers the client's need due to weight gain, complete and fax the "Request For Additional MG's of Synagis® Due to Client Weight Increase" form, DSHS 13-770. The Department will update the authorization to reflect an appropriate quantity and fax back confirmation of the increased dosage.

## Evaluation of Authorization Requests

The Department physicians will evaluate requests for authorization to determine whether the client falls within 2009 AAP guidelines for the administration of Synagis®. The Department will fax an approval or denial to the requestor.

Please allow at least five business days for the Department to process the authorization request. You may verify the status of a pending authorization by calling the Medical Assistance Customer Service Center at 1-800-562-3022.

Department forms may be downloaded at the Department/MPA forms website at: http://www.dshs.wa.gov/msa/forms/eforms.html.

# National Drug Code Format

- **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. **[WAC 388-530-1050]**

- The NDC ***must*** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros."

**For example:** The label may list the NDC as 123456789when, in fact, the correct NDC is 01234056789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. ***The Department will deny claims for drugs billed without a valid 11-digit NDC.***

***Electronic 837-P Claim Form Billing Requirements***

Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

***CMS-1500 Claim Form Billing Requirements***

When billing using a **paper** CMS-1500 Claim Form for **two or fewer drugs on one claim form,** you must list the 11-digit NDC in ***field 19*** of the claim form must be listed **exactly** as follows (*not all required fields are represented in the example*):

| 19. 54569549100 Line 2 / 00009737602 Line 3 |
|---|

| Line | Date of Service | Procedure Code | Charges | Units |
|---|---|---|---|---|
| 1 | 07/01/07 | 99211 | 50.00 | 1 |
| 2 | 07/01/07 | 90378 | 1500.00 | 2 |
| 3 | 07/01/07 | J3420 | 60.00 | 1 |

***DO NOT*** attempt to list more than two NDCs in field 19 on the paper CMS-1500 Claim Form. When billing for more than 2 drugs, you must list the additional drugs must be listed on additional claim forms. **Do not bill more than 2 drugs per claim form.**

**If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.**

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

| Pounds | Dose |
|---|---|
| 0-17 | 1 ml |
| 18-34 | 2 ml |
| 35-50 | 3 ml |
| 51-67 | 4 ml |
| 68-84 | 5 ml |
| 85-100 | 6 ml |
| 101-117 | 7 ml |
| 118-134 | 8 ml |
| 135-150 | 9 ml |

| Pounds | Dose |
|---|---|
| 151-167 | 10 ml |
| 168-184 | 11 ml |
| 185-200 | 12 ml |
| 201-217 | 13 ml |
| 218-234 | 14 ml |
| 235-250 | 15 ml |
| 251-267 | 16 ml |
| 268-284 | 17 ml |
| 285-300 | 18 ml |

  ✓ RIG is sold in either 2 ml or 10 ml vials.

  ✓ One dose is allowed per episode.

  ✓ Bill one unit for each 2 ml vial used per episode.

  **Examples:**

  ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or

  ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill the Department for immune globulins using the HCPCS procedure codes listed below. The Department does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

| Noncovered CPT Code | Covered HCPCS Code |
|---|---|
| 90281 | J1460-J1560 |
| 90283 | J1566 |
| 90284 | J1562 |
| 90291 | J0850 |
| 90384 | J2790 |
| 90385 | J2790 |
| 90386 | J2792 |
| 90389 | J1670 |
| | Q4087, Q4088, Q4091, and Q4092 |

- The Department pays for injectable (see fee schedule) and nasal flu vaccines (CPT 90660) from October 1-March 31 of each year.

**Note:** CPT 90660 is free from DOH for clients 3-18 years of age and is covered by the Department for clients 19-49 years of age.

# Therapeutic or Diagnostic Injections

**(CPT codes 96360-96379) [Refer to WAC 388-531-0950]**

- If no other service is performed on the same day, you may bill a subcutaneous or intramuscular injection code (CPT code 96372) in addition to an injectable drug code.

- The Department does not pay separately for intravenous infusion (CPT codes 96372-96379) if they are provided in conjunction with IV infusion therapy services (CPT codes 96360-96361or 96365-96368).

- The Department pays for only one "initial" intravenous infusion code (CPT codes 96360, 96365, or 96374) per encounter unless:

  ✓ Protocol requires you to use two separate IV sites; or

  ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second "initial" service code with modifier 59.

- The Department does not pay for CPT code 99211 on the same date of service as drug administration CPT codes 96360-96361, 96365-96368, or 96372-96379. If billed in combination, the Department denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, the Department will deny the E&M code.

- **Concurrent Infusion:** The Department pays for concurrent infusion (CPT code 96368) only once per day.

## Hyalgan/Synvisc/Euflexxa/Orthovisc

- The Department reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan, Synvisc, Euflexxa, or Orthovisc.

- The Department allows a maximum of 5 Hyalgan, 3 Euflexxa, or 3 Orthovisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.

- This series of injections may be repeated at 12-week intervals.

The injectable drug must be billed after all injections are completed.

- Providers must bill for Hyalgan, Synvisc, Euflexxa, and Orthovisc using the following HCPCS codes:

| HCPCS Code | Description | Limitations |
|---|---|---|
| J7321 | Hyalgan/supartz inj per dose | Maximum of 5 injections<br>Maximum of 5 units |
| J7323 | Euflexxa inj per dose | Maximum of 3 injections<br>Maximum of 3 units |
| J7324 | Orthovisc inj per dose | Maximum of 3 injections<br>Maximum of 3 units |

Providers must bill for Synvisc, using the following HCPCS code:

| HCPCS Code | Description | Limitations |
|---|---|---|
| J7325 | Synvisc inj per dose | One unit equals one mg. One injection covers a full course of treatment per knee. Limited to one injection per knee in a six-month period. Maximum of 48 units per knee, per course of treatment. |

- Hyalgan, Synvisc, Euflexxa, and Orthovisc injections are covered only with the following ICD-9-CM diagnosis codes:

| Diagnosis Code | Description |
|---|---|
| 715.16 | Osteoarthritis, localized, primary lower leg. |
| 715.26 | Osteoarthritis, localized, secondary, lower leg. |
| 715.36 | Osteoarthritis, localized, not specified whether primary or secondary, lower leg. |
| 715.96 | Osteoarthritis, unspecified whether generalized or localized, lower leg. |

- The injectable drugs must be billed after all injections are completed.

- Bill CPT injection code 20610 each time an injection is given, up to a maximum of: 5 Hyalgan injections, 3 Euflexxa injections, 3 Orthovisc injections, and 1 or 3 Synvisc injections (depending on formula).

- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

## Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, the Department limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although specific memoranda have been superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

| Procedure Code | Brief Description | Limitation Restricted to ICD-9-CM |
|---|---|---|
| J0637 | Caspofungin acetate | 112.84 (candiadal esophagitis); 117.3 (aspergillosis) |
| J0725 | Chorionic gonadotropin/1000u | 752.51 (Undescended testis) |
| J1055 | Medroxyprogester acetate inj (depo provera) | Females-only diagnoses V25.02, V25.40, V25.49, V25.9. (contraceptive mgmt) allowed once every 67 days Males-diagnosis must be related to cancer |
| J1212 | Dimethyl sulfoxide 50% 50 ML | 595.1 (chronic intestinal cystitis) |
| J1595 | Injection glatiramer acetate | 340 (multiple sclerosis) |
| J1756 | Iron sucrose injection | 585.1-585.9 (chronic renal failure) |
| J2325 | Nesiritide | No diagnosis restriction. Restricted use only to cardiologists |
| J2501 | Paricalcitol | 585.6 (chronic renal failure) |
| J2916 | Na ferric gluconate complex | 585.6 (chronic renal failure) |

| Procedure Code | Brief Description | Limitation Restricted to ICD-9-CM |
|---|---|---|
| J3285 | Treprostinil, 1 mg | 416.0-416.9 (chronic pulmonary heart disease) |
| J3420 | Vitamin B12 injection | 123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24 |
| J3465 | Injection, voriconazole | 117.3 (aspergillosis) |
| J3487 | Zoledronic acid (Zometa®), 1 mg | 198.5, 203.00, 203.01, 275.42 (hypercalcemia) |
| J3488 | Zoledronic acid (Reclast®), 1 mg | 731.0, 733.01 |
| J9041 | Bortezomib injection | 200.40 – 200.48 (mantle cell lymphoma) or 203.00-203.01 (multiple myeloma and immunoproliferative neoplasms) |
| Q3025 | IM inj interferon beta 1-a | 340 (multiple sclerosis) |
| Q3026 | Subc inj interferon beta-1a | 340 (multiple sclerosis) |
| J2323 | Natalizumab injection | 340 (multiple sclerosis). 555.0, 555.1, 555.2, 555.9 (crohn's disease). Requires PA. See *Important Contacts* section for information on where to obtain the authorization form. |

### Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

| Procedure Code | Brief Description | Limitation Restricted to ICD-9-CM |
|---|---|---|
| 11980 | Implant hormone pellet(s) | 257.2, 174.0-174.9 |
| S0139 | Minoxidil, 10 mg | 401.0-401.9 (essential hypertension) |
| S0189 | Testosterone pellet 75 mg | 257.2, 174.0-174.9 and only when used with CPT code 11980 |

## Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

# Clozaril Case Management

- Providers must bill for Clozaril case management using CPT code 90862 (pharmacologic management).
- The Department reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case management.
- The Department reimburses providers for Clozaril case management when billed with ICD-9-CM diagnosis codes 295.00 – 295.95 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case management.
- The Department does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

# Botulism Injections **(HCPCS code J0585 and J0587)**

The Department requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**. The Department requires PA for CPT code 95874 when needle electromyography for guidance is used.

The Department approves Botulism injections with PA:

- For the treatment of:
  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

## Physicians Billing for Compound Drugs

To bill for compounding of drugs enter J3490 as the procedure code. Enter the NDC for the main ingredient in the compound on the line level. Put compound in the notes field. Attach an invoice showing all of the products with NDCs and quantities used in the compound. Claims are manually priced per the invoice.

## Vivitrol (J2315)

The Department requires prior authorization for Vivitrol. It is also available when prior authorized through the pharmacy Point-of Sale (POS) system.